Letter of Medical Necessity

Patient Name: _____

Participant Name: _____

Participant Employer Name: _____

To be filled out by licensed practitioner:

Medical Condition: _____

I refer _____ to Transform Weight Loss Program for weight loss.

(patient name)

Physician Comments:

_____

_____

Physician's Signature: _____ Date: _____

Patient should keep this letter for tax purposes for proof necessary for reimbursement under a FSA, HRA, or Health Insurance Coverage Plan.